MONTANA
Department of Public Health & Human Services

March 1, 2008

Montana Healthcare Programs Notice

Prospective Payment Outpatient Hospital Providers (Excludes CAH and IHS Facilities)

Enhanced Claims Editing - Bloodhound ClaimsGuard®

Beginning December 1, 2007, healthcare programs administered by the Department of Public Health and Human Services implemented enhanced claims editing to identify situations where correct procedure coding principles needed to be improved for 1500 billers. These edits are based on nationally recognized sources such as the Centers for Medicare and Medicaid (CMS) Correct Coding Initiative (CCI) and the American Medical Association (AMA) Current Procedure Terminology (CPT®) guidance. A subset of these edits currently exists in the Medicaid Management Information System (MMIS). Integrating ClaimsGuard® into the MMIS will apply national standards more consistently across a wide variety of Montana's Healthcare Programs.

This change may affect any providers who bill for services using CPT®/HCPCS procedure codes; however, specific edits may not apply to certain provider types. These edit modules may be phased in over time and may include enhanced editing related to the use of:

- Add-on codes,
- Implementation of the Correct Coding Initiative Edits (CCI) developed by CMS,
- Appropriate use of Evaluation and Management (E & M) codes for new and established patients, and multiple visits on the same day,
- Appropriate billing within a global surgical period,
- Appropriate billing of incidental services,
- Appropriate billing for service by age and gender,
- Medical necessity based on National Coverage Determinations as documented by CMS,
- Identification of duplicate services in certain instances, and
- Appropriate bundling of component procedures.

As each edit module is implemented, provider notices will be published to provide guidance on how to improve procedure coding in accordance with published AMA and/or CMS standards. Each new exception will be mapped to a reason code for communication to the provider.

The first modules relating to add-on codes, new visit E & M codes and multiple E & M services for same date of service will be activated April 1, 2008, for Prospective Payment Outpatient Hospitals (in-state prospective payment hospitals, all out of state and border hospitals). This notice specifically excludes Critical Access Hospitals (CAH) and Indian Health Service (IHS) hospitals. Other edit modules will be implemented in the future.

Add-on Codes

The first edit to be activated relates to the use of add-on codes. Both CPT® and CMS define codes that require the presence of a primary procedure code for appropriate coding. The CPT® manual describes add-on codes as "procedures/services that are always performed, by the same physician" and "are always performed in addition to the primary service/procedure, and must never be reported as stand-alone codes."

Examples of these codes include:

90471 IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS INTRADERMAL SUBCUTANEOUS OR INTRAMUSCULAR INJECTIONS); ONE VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)

90472 IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, IM & JET INJECTIONS &/OR INTRANASAL OR ORAL ADMIN); EACH ADDITIONAL VACCINE (SINGLE OR COMBO)

90473 IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; ONE VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)

When billing these codes, the first immunization should be billed with 90471 or 90473, depending on the type of vaccine. Additional vaccines should be billed with 90472, which is the add-on code. Note that 90472 must be used in conjunction with 90471 or 90473 and that 90471 cannot be reported with 90473 (or vice versa).

90760 INTRAVENOUS INFUSION, HYDRATION; INITIAL, UP TO 1 HOUR

90761 INTRAVENOUS INFUSION, HYDRATION; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROC)

Code 90761 is an add-on code and should be reported in conjunction with 90760.

90767 INTRAVENOUS INFUSION FOR THERAPY PROPHYLAXIS OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); ADDITIONAL SEQUENTIAL INFUSION UP TO 1 HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

Code 90767 should be reported in conjunction with 90765, 90774, 96409, or 96413 when provided as a secondary or subsequent service after a different initial service.

88141 CYTOPATHOLOGY CERVICAL OR VAGINAL (ANY REPORTING SYSTEM); REQUIRING INTERPRETATION BY PHYSICIAN (LIST SEPARATELY IN ADDITION TO CODE FOR TECHNICAL SERVICE)

Code 88141 must be used in conjunction with 88142-88154, 88164-88167, and 88174-88175.

83901 MOLECULAR DIAGNOSTICS; AMPLIFICATION OF PATIENT NUCLEIC ACID MULTIPLEX EACH ADDITIONAL NUCLEIC ACID SEQUENCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

Code 83901 must be used in conjunction with 83900.

These are just a few examples of codes that must be billed as an add-on to a primary code. Please consult your current AMA guidance for complete information on codes that should be billed with a primary code.

After April 1, 2008, Montana Medicaid will require codes that are designated as add-on codes to be billed with the appropriate primary code(s). Procedures that are billed without the primary code will be denied. The reason and remark code (N122) will specify that an add-on code cannot be billed by itself.

New Visit E & M Codes

According to the American Medical Association (AMA), a new patient is one who has not received any professional services from a physician, or another physician of the same specialty who belongs to the same group, within the past three years.

If the patient has received services from the same provider within the past three years, a new patient Evaluation and Management is not appropriate. The appropriate established patient code should be billed. This editing will be performed on a variety of New Visit Evaluation and Management codes including but not limited to:

- 99201-99205 OFFICE/OUTPATIENT VISIT, NEW
- 99381-99385 PREV VISIT, NEW, INFANT
- 92002-92004 EYE EXAM, NEW PATIENT
- 99324-99328 DOMICIL/R-HOME VISIT NEW PAT

For Emergency Department Evaluation and Management codes, no distinction is made between new and established patients.

Please consult your AMA guidance for complete information on appropriately billing new visit Evaluation and Management codes.

After April 1, 2008, Montana Medicaid will require correct codes be used so that all established patients be billed with appropriate established patient Evaluation and Management codes. Established patients that are billed with new visit Evaluation and Management codes will be denied. The reason and remark code (N113) will specify that only one initial visit is covered per physician, group practice or provider.

Multiple E & M Services on Same Date of Service

Enhanced editing will include identification of claims where multiple Evaluation and Management (E & M) services are billed on the same date of service.

According to the Centers for Medicare and Medicaid Services (CMS), Chapter XI Medicine, Evaluation and Management Services, CPT Codes 90000-99999, National Correct Coding Policy Manual for Part B Medicare Carriers, "CPT codes for evaluation and management services are principally included in the group of CPT codes, 99201-99499. The codes are divided to describe the place of service (e.g. office, hospital, home, nursing facility, emergency department, critical care, etc.), the type of service (e.g. new or initial encounter, follow-up or subsequent encounter, consultation, etc.), and various miscellaneous services (e.g. prolonged physician service, care plan oversight service, etc.). Because of the nature of evaluation and management services, which mostly represent cognitive services (medical decision making) based on history and examination, correct coding primarily involves determination of the level of history, examination and medical decision making that was performed rather than reporting multiple codes. Only one evaluation and management service code may be reported per day."

Some examples include billing the following codes together:

99431, INITIAL CARE, NORMAL NEWBORN
99440, NEWBORN RESUSCITATION
As these codes normally represent services that are mutually exclusive, 99431 would normally be denied when billed together by the same practitioner.

99436, ATTENDANCE, BIRTH
99440, NEWBORN RESUSCITATION
As these codes normally represent services that are mutually exclusive, 99436 would normally be denied when billed together by the same practitioner.

99392, PREV VISIT, EST, AGE 1-4
99213, OFFICE/OUTPATIENT VISIT, EST
Unless these E & M services are for unrelated problems, only one E & M service should be billed.

The exception to this rule is if evaluation and management services are provided for an unrelated problem. In these instances, the subsequent evaluation and management services should be appended with an appropriate modifier to indicate that the service was a significant, separately identifiable service provided on the same day.

Please consult your AMA and CMS guidelines for complete information on appropriately billing multiple evaluation and management codes on the same day.

After April 1, 2008, Montana Medicaid will reimburse only multiple E & M procedures for unrelated problems that are billed with an appropriate modifier. Procedures that are billed without the appropriate modifier will be denied. Remark code M86 on the remittance advice/835 transaction specifies the service is denied because payment has already been made for the same/similar procedure within set time frame.

Contact Information

For claims questions or additional information, contact Provider Relations:

Provider Relations toll-free in- and out-of-state: 1-800-624-3958
Helena: (406) 442-1837
E-mail: MTPRHelpdesk@ACS-inc.com

Visit the Provider Information website:

http://www.mtmedicaid.org